

PROVIDER REGISTRATION FORM

PRACTICE NAME				DATE	
PHONE		FAX		WEBSITE	
PRACTICE ADDRESS	Street				
	City		State	Zip Code	
PHYSICIAN NAME	NPI Number	Phone		Email	
PHYSICIAN NAME	NPI Number	Phone		Email	
PHYSICIAN NAME	NPI Number	Phone		Email	
OFFICE MANAGER NAME		Phone		Email	

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
PRACTICE HOURS						
SPECIMEN PICKUP TIME BY COURIER						

ORDERING	<input type="checkbox"/> PAPER REQUISITION	<input type="checkbox"/> EMR
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REPORT DELIVERY	<input type="checkbox"/> FAX	<input type="checkbox"/> EMR	<input type="checkbox"/> REGULAR MAIL	<input type="checkbox"/> COURIER
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PROXY APPROVAL FOR REQUISITIONS Please complete one of the following:

- A.** I approve all clinical support staff from my organization to be proxies for ordering/requesting dermatopathology tissue processing and services.

Physician Signature

- B.** I approve the following staff from my organization to be proxy for ordering/requesting dermatopathology tissue processing and services.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Physician Signature

FOR LAB USE ONLY

Orientation Provided:
Procedure Manual Provided:
Initial Supply Pack Sent:
Medicare Opt-out Form Received:
Physician's Fax Verified:

PRACTICE ID

Comments: